Supreme Court, U.S.
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No.

IN THE
SUPREME COURT OF THE UNITED STATES

UNITED STATES OF AMERICA, *EX REL*, J. EDWARD WALTERS,

Petitioner,

v.

THE DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, PROVIDENCE HOSPITAL, SETON MEDICAL MANAGEMENT, INC., AND ASCENSION HEALTH, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS FOR REVIEW

1. Whether submitting a false Annual Cost Report to Medicare which will influence future payment rates is a violation of the Federal False Claims Act.

2. Whether the Eleventh Circuit's decision in this case is in conflict with decisions of the Tenth, Fourth and D.C. Circuits.

TABLE OF CONTENTS

PARTIES....1

CORPORATE DISCLOSURE STATEMENT....1

CITATIONS TO OPINIONS BELOW....1

STATEMENT OF JURISDICTION....1

STATUTES....2

RULES OF PROCEDURE....2

STATEMENT OF THE CASE....3

Course of Proceedings and Disposition in the Courts Below....3

Statement of Facts....3

ARGUMENT....5

CONCLUSION....9

APPENDIX....11

Eleventh Circuit Opinion....A-1

SUPPLEMENTAL APPENDIX

District Court Opinion....SA-1

TABLE OF AUTHORITIES

CASES **PAGE**

Harrison v. Westinghouse Savannah River Company
176 F.3d 776, 785 (4th Cir. 1999).....8

Harrison v. Westinghouse Savannah River Company
352 F. 3d 908 (2003).....7

Kennard v. Comstock
363 F.3d 1039 (2004).....7

Pogue v. Diabetes Treatment centers of America, Inc.
238 F. Supp. 2d 258 (D.C. D.C., 2002).....8

United States ex rel. Clausen v. lab. Corp. of Am.
290 F.3d 1301, 1311 (11th Cir. 2002).....7

STATUTES AND OTHER AUTHORITIES **PAGE**

31 U.S.C. § 3729(a)(1)(2)(3).....2,3,6

42 U.S.C. § 1395ww(f)(1)(A).....2,6,8

FRCP 9(b).....2,3

LIST OF PARTIES

The parties are listed in the caption of the case.

CORPORATE DISCLOSURE STATEMENT

All of the Defendants claim to be non-profit corporations. They are affiliated with the Catholic Church, but the nature of the affiliation is unknown to Petitioner. Defendant Ascension Health, Inc. is the successor-in-interest to Daughters of Charity National Health System, Inc. None of the Defendants/Respondents issues publicly traded stock, to Petitioner's best knowledge.

CITATIONS TO OPINIONS BELOW

Neither the Appeals Court decision, nor the District Court opinion was published. The Eleventh Circuit Cause No. is 04-10915, the District Court for the Southern District of Alabama, Southern Division No. is 99-0932-CB-C.

For reasons unknown, the Eleventh Circuit changed the style of the case. The style listed on the cover page of this document is the style of the case in the District Court.

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

The Eleventh Circuit opinion and judgement was filed on July 2, 2004.

STATUTES

31 U.S.C. § 3729

(a) Liability for certain acts. -- Any person who --

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

••••

is liable to the United States Government...

42 U.S.C. § 1395ww

(f) Reporting of costs of hospitals receiving payments on basis of prospective rates

(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d) of this section.

RULES OF PROCEDURE

FRCP 9(b)

Fraud, Mistake, Condition of the Mind. In all averments of fraud or mistake, the circumstances constituting fraud or

mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.

STATEMENT OF THE CASE

Course of Proceedings and Disposition in the Courts Below

Plaintiff filed an action under the Federal False Claims Act, 31 U.S.C. § 3729 et seq., against the Daughters of Charity National Health System, Inc. which at the time in question owned or managed a number of hospitals throughout the United States, including Providence Hospital in Mobile, Alabama, Providence Hospital itself, Seton Medical Management, Inc., which provided services to Providence Hospital and Ascension Health, Inc. which, at some point assumed the assets and liabilities of Daughters of Charity.

Defendants filed motions to dismiss claiming Plaintiff had failed to state a claim pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). The District Court, in its order of January 28, 2004 granted Defendants' motions and dismissed the case.

Appeal was taken to the United States Court of Appeals for the Eleventh Circuit, which affirmed the dismissal on July 2, 2004.

Statement of Facts

Petitioner J. Edward Walters worked for Providence Hospital from 1988 until March, 1998. He was, at the time he

was terminated, Director of the Diabetes Center, the Cholesterol Center and the Employee Assistance Program.

In January, 1998, each director of department at the hospital became responsible for his or her department's billing, including the accuracy of billing. In reviewing the medical records and bills for patients, Walters noticed that patients were being billed for drugs and medical supplies which they did not receive.

When he questioned persons involved with billing, he learned that this was systemic.

Walters copied one Medicare patient's medical records and bill. (F.G.) By comparing the medication administration records and the itemized bill, Walters determined that the overcharges for drugs, supplies and tests which were not received by the patient were at least $1,185.03.

He later discovered that Providence Hospital submitted a claim to Medicare which included an itemized bill containing the overcharges.

Under the Prospective Payment System now in effect for most hospital medicare reimbursement, hospitals are paid based upon the main diagnosis of the patient in question. Thus, even though the bill for the patient whose record Walters copied totaled $35,464.04, Providence Hospital was only paid $19,682.53.

However, as required by statutes and regulations governing Medicare, Providence Hospital submitted its Annual Cost Report for the relevant period. This report

included "Medical Supplies Charged to Patients" and "Drugs Charged to Patients." These charges were almost $7,000,000.00.

Walters alleged that "These figures undoubtedly contain the overcharges to patient F.G. and, because these types of overcharges are systemic to Providence Hospital, the Cost Report submitted by Providence Hospital is greatly overstated as to drugs and medical supplies for patients."

Walters also alleged that, "The overcharges became a part of the computations considered by the Health Care Financing Administration, and assuming that the same system is in place, continue to be part of the computations by the Center for Medicare and Medicaid Services, which help to determine reimbursement rates for hospitals."

Walters attached copies of the pertinent medical records, bill, claim to Medicare and Cost Report to the pleadings considered by the District Court and Appeals Court. The facts, as stated above are undisputed, as found by both courts.

ARGUMENT

Petitioner attached the itemized statement which the hospital sent to Medicare in order to be reimbursed. The statement contained charges for drugs and medical supplies which were not received by the Medicare beneficiary.

Under the current payment scheme, the hospital did not **immediately** receive payment for the overcharges. However, the hospital included these overcharges in its

Annual Cost Report submitted to Medicare pursuant to Federal Statutes (42 U.S.C. § 1395ww, specifically (f)(1)(A)).

The hospital had to submit a statement of the services it provided for the Medicare patient. The False Claim Act prohibits presenting a false claim for payment. 31 U.S.C. § 3729(a)(1).

Recognizing that hospitals are not paid the total amount that they claim they spent on a given Medicare patient, but are reimbursed, based in part by what the Federal Government determines to be the average cost of providing care to all Medicare patients. Petitioner included portions of the hospital's Annual Cost Report for the relevant period.

The court below decided for the hospital because it did not immediately receive any extra money by reason of either the initial claim or the Cost Report for that year. Thus, if the ruling is allowed to stand it means that hospitals may inflate their costs which are then used by the Secretary of Health and Human Services to determine the hospitals' reimbursement rates.

Obviously, such blatant overstatement of costs has grave consequences for the Treasury of the United States. The question involved in this Petition is whether it may be dealt with under the False Claims Act.

The court below stated that:

> "'Without the presentment of...a [false or fraudulent] claim, while the practices of an entity that provides services to the

> Government may be unwise or improper, there is simply no actionable damage to the public fisc as required under the FCA.' United States ex rel. Clausen v. Lab. Corp. of Am., 290 F.3d 1301, 1311 (11th Cir. 2002), cert. denied, 537 U.S. 1105, 123 S. Ct. 870, 154 L. Ed. 2d 774 (2003)."

The ruling conflicts with rulings by at least three other circuit courts of appeal.

The Tenth Circuit in *Kennard v. Comstock*, 363 F.3d 1039 (2004) dealt with a case alleging fraudulent underpayment of oil royalties to an Indian tribe. The royalties, in question were not paid to the U.S. Government, but were transmitted to the Mineral Management Service of the United States Department of the Interior. Under the pertinent regulations, the Mineral Management Service is to have "a comprehensive...accounting and auditing system...to accurately determine oil and gas royalties." 363 F.3d at 1048.

The public fisc of the United States was in no way damaged by the actions of the Defendant in *Kennard.*

The Fourth Circuit in *Harrison v. Westinghouse Savannah River Company*, 352 F. 3d 908 (2003), affirmed an award of attorneys fees in a False Claims Act case where the Defendant had submitted a false certification but no actual damages were proved.

The Fourth Circuit in a previous decision in the same case stated that liability under the False Claims Act must meet a judicially imposed standard of materiality, which depends

on "whether that false statement has a natural tendency to influence agency action or is capable of influencing agency action." *Harrison v. Westinghouse Savannah River Company*, 176 F. 3d 776, 785 (4th Cir. 1999).

Arguably, the District of Columbia Circuit lines up with the Fourth and the Tenth, at least according to *Pogue v. Diabetes Treatment Centers of America, Inc.*, 238 F. Supp. 2d 258 (D.C. D.C., 2002) which held that by submitting a claim the Defendant impliedly certified that it had complied with all statutes and regulations.

Section 1395ww of Title 42, United States Code sets out the criteria for payments to hospitals for inpatient hospital services to Medicare beneficiaries. The provision is voluminous and is on a par with the Internal Revenue Code for difficulty. However, throughout the section words such as "the average of such costs for all hospitals in the same grouping," appear and indicate that such averages shall be used by the Secretary of Health and Human Services to determine the reimbursement rate to hospitals for care of Medicare patients.

Although not immediately reimbursed, the individual claims and the Annual Cost Reports submitted by hospitals contribute to the averages considered by the Secretary in determining reimbursement rates. By inflating its costs for drugs and medical supplies, Defendant hospital's false statements had "a natural tendency to influence agency action or [was] capable of influencing agency action." *Harrison*, 176 F. 3d at 785.

Whether Defendant Providence Hospital has received

any extra funds by reason of its false claims and cost reports is, of course, subject to proof. However, Providence Hospital is one of many hospitals owned by Defendant Ascension Health, Inc. which, according to its website, claims to have facilities in twenty states. (www.ascensionhealth.org)

Even if the price Medicare pays for various hospital procedures only increases by a few dollars per patient, the cost to the Government increases by millions or more. In March of this year, the Medicare Board of Trustees reported to Congress that Medicare's financial condition has significantly deteriorated, partly because of exploding health costs. New York Times, March 24, 2004, page 1.

CONCLUSION

Congress has given the courts a powerful weapon to combat fraud against the Treasury. But, if the courts are going to allow individuals and corporations to scam the system because False Claim Act plaintiffs have not participated in the fraud and thus, do not have insider knowledge, as was the situation in this case, the weapon is ineffectual for the great majority of fraud against the Government and taxpayers.

The court should grant certiorari and allow Petitioner to help save Medicare by exposing the huge overstatement of costs by hospitals.

Respectfully submitted,

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APPENDIX

[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 01-10915 [FILED
Non-Argument Calendar JULY 02, 2004]

D. C. Docket No. 99-00392-CV-1-CB-C

J. EDWARD WALTERS, bringing this action on behalf of the United States of America,

Plaintiff-Appellant,

versus

DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, INC., d.b.a. Providence Hospital, SETON MEDICAL MANAGEMENT, INC., PROVIDENCE HOSPITAL, ASCENSION HEALTH, Ascension Health, Inc.,

Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Alabama

(July 2, 2004)

Before ANDERSON, MARCUS, and PRYOR, Circuit Judges.

PER CURIAM:

Qui tam relator, J. Edward Walters, appeals the district court's dismissal of his claim under the False Claims Act ("FCA"), 31 U.S.C. § 3729 et seq., for failure to plead fraud with particularity and failure to state a claim. On appeal, Walters argues that his complaint sufficiently alleged FCA claims arising from the alleged practice of overcharging for prescription medicines and medical supplies by Defendant, Providence Hospital ("Providence").[1]

We review de novo the dismissal of a complaint for failure to state a claim, accepting all allegations contained in the complaint as true and construing the facts in a light most favorable to the plaintiff. See Harper v. Thomas, 988 F.2d 101, 103 (11th Cir. 1993). A complaint may not be dismissed "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Pataula Elec. Membership Corp. v. Whitworth, 951 F.2d 1238, 1240 (11th Cir.) (quoting Scheuer v. Rhodes, 416 U.S. 232, 236 (1974)), cert. denied, 506 U.S. 907(1992).

Upon thorough review of the record, as well as careful consideration of the parties' briefs, we find no reversible error and affirm.

The relevant facts, as found by the district court, are undisputed. Walters was formerly the Director of the Diabetes Center, the Cholesterol Center, and the Employee Assistance Program, all located at Providence Hospital in Mobile, Alabama, where Walters was employed from March

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[1] Walters also sued Seton Medical Management, Inc., and Daughters of Charity National Health System ("Daughters of Charity"), both of whom participate in the ownership and/or management of Providence. Defendant Ascension Health, Inc. is the successor-in-interest to Daughters of Charity.

1988 through March 1998. According to Walters's complaint, he was terminated shortly after he discovered the billing practices that form the basis of his suit.

Walters alleged that Providence had provided health care services to beneficiaries of Medicare, Medicaid, and other federally-funded programs and was a participating provider with the Center for Medicaid Services, formerly the United States Health Care Financing Administration. In January 1998, Providence delegated responsibility for billing practices to the directors of its various departments. In reviewing those bills for which he was responsible, Walters alleges that he determined there were discrepancies between the bills and the medical records for some former patients. Walters alleged that he had reviewed a number of patients' bills and records and found a pattern of charges for drugs and supplies that were not received by the patients.

Walter copied only one patient's record. Thus, the complaint's only reference to specific overcharges concerned a patient referred to as "F.G." Walters alleged that F.G. was in the hospital from June 4 to June 10, 1997 and that Providence had submitted a Medicare claim for services rendered. According to Walters, the bill sent to Medicare included $1,185.03 in overcharges for drugs and medical supplies never provided to F.G.

Notably, based on the method of reimbursement used under the Medicare system, Providence never received payments from Medicare for the alleged overcharges associated with F.G. As Walters concedes, the alleged overcharges were not used in calculating the final amount submitted for reimbursement to Medicare. The district court explained the Medicare reimbursement system as follows:

> To determine whether any of plaintiff's claims allege a cause of action under the FCA, it is necessary to understand, first, how the Medicare reimbursement system operates. Medicare does not reimburse a healthcare provider for the actual charge submitted, nor is the reimbursement based upon that amount. Instead, "Medicare groups standardized medical codes for patients, diseases, and procedures into diagnostic related groups ('DRG') that provide the basis for [the] PPS [prospective payment system]. The average cost of care for each DRG determines the reimbursement amount, rather than the actual cost of care to a beneficiary." United States v. Whiteside, 285 F.3d 1345, 1346 (11th Cir. 2002). Health care providers are reimbursed at a preestablished flat rate for each DRG. Transitional Hops. Corp. of Louisiana, Inc. v. Shalala, 222 F.3d 1019, 1021 (D.C. Cir. 2000). . . .
>
> Annual cost reports submitted by the health care provider are part of the reimbursement equation because they include certain costs, such as outlier costs, that may be reimbursed by Medicare in addition to those costs taken into account in the PPS/DRG payments.

District Court Order at 7-8.

In 1997, Providence submitted its annual Cost Report, which covered the relevant time period from July 1,1996 through

June 30,1997. The Cost Report states that Providence's annual costs for "Medical Supplies" totaled $3.3 million, while its total annual costs for "Drugs Charged to Patients" totaled $3.6 million.

In his complaint, Walters conceded that Providence was reimbursed by Medicare pursuant to the above-described PPS/DRG system, and that Medicare never paid the overcharged amount. Walters contended that the United States was, nevertheless, damaged by Providence's inclusion of the overcharges in the initial claims -- the claims that were not used in calculating the reimbursement amount -- and the Cost Report. Walters further alleged that the "thousands of other[] [overcharges] . . . were undoubtedly submitted [thereby] affect[ing] the overall reimbursement rates of hospitals, including Providence Hospital and the hospitals affiliated with the other defendants. While the amount attributable to defendants may be difficult to calculate, it is real and substantial." Walters sought treble damages and penalties, pursuant to the FCA, as well as attorneys' fees, costs, and an appropriate award for himself for bring the qui tam claim.

Defendants moved to dismiss Walters's complaint, alleging that it failed to allege fraud with particularity, as required by Fed. R. Civ. P. 9(b), and that it failed to state an FCA claim and thus, warranted dismissal pursuant to Fed. R. Civ. P. 12(b)(6). The district court granted the motion, concluding that (1) Walters's general allegations of "systematic" overbilling were "broad and conclusory" and insufficient to plead a fraud claim under Rule 9(b); and (2) Walters's specific allegations of overbilling with respect to one patient, F.G., were insufficient to state an FCA claim because the alleged overcharges were not material to the decision on the Medicare reimbursement amount, which is determined by a fixed schedule predetermined by Medicare (the PPS/DRG system). This appeal followed.

The FCA imposes liability on "[a]ny person who . . . knowingly presents, or causes to be presented, to an officer or employee of the United States Government. . .a false or fraudulent claim for payment." 31 U.S.C. § 3729(a)(1). "Without the presentment of. . . a [false or fraudulent] claim, while the practices of an entity that provides services to the Government may be unwise or improper, there is simply no actionable damage to the public fisc as required under the FCA." United States ex rel. Clausen v. Lab. Corp. of Am., 290 F.3d 1301, 1311 (11th Cir.2002), cert. denied, 537 U.S. 1105, 123 S. Ct. 870, 154 L. Ed. 2d 774 (2003).

We have held that a False Claims Act relator alleging a health plan administrator improperly submitted claims to Medicare must comply with Rule 9(b). See United States v. Laboratory Corp. of Am., Inc., 290 F.3d 1301, 1308 (11th Cir. 2002), cert. denied, 537 U.S. 1105, 123 S. Ct. 870, 154 L. Ed. 2d 774 (2003). Rule 9(b) provides that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." Fed. R. Civ. P. 9(b). When Rule 9 is implicated, plaintiffs must plead not only the general nature of their injuries but also the specifics of how and when they were injured. See, e.g., Brooks v. Blue Cross & Blue Shield of Fla., Inc., 116 F.3d 1364, 1380-81 (11th Cir. 1997). Under Rule 9(b), a plaintiff alleging fraud must plead "(1) the precise statements, documents, or misrepresentations made; (2) the time, place, and person responsible for the statement; (3) the content and manner in which these statements misled the Plaintiffs; and (4) what the defendants gained by the alleged fraud." Id.

Here, the district court held that the complaint's general allegations of fraud, consisting of "broad and conclusory" statements, were insufficient under Rule 9(b). We agree. We are unpersuaded by Walters's reliance on our decision in United States

ex rel. Hill v. Morehouse Med. Assocs., Inc., 2003 WL 22019936 (11th Cir. Aug. 15, 2003). Unlike in Hill, Walter was not an insider who had observed and participated in the billing process and Walters did not have firsthand knowledge of the billing practices at issue here. Rather, as the district court found, "Plaintiff's similarity with Hill begins and ends with the fact that he is a former employee of one of the defendants." Simply put, pursuant to Clausen, conclusory allegations of fraudulent billing do not satisfy Rule 9(b)'s requirements and cannot support an FCA claim. We likewise find no error in the district court's Fed. R. Civ. P. 12(b)(6) analysis of Walters's more specific allegations of fraud.

AFFIRMED.